HEALTH CARE FSA
Reimbursement Claim Form

ACCOUNT HOLDER INFORMATION

Last Name

First Name

ID Code (last 4 digits)*

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. If the expense(s) claimed is covered under my Employer's Health Reimbursement Arrangement, I certify that the patient for each claim being submitted is covered under an Affordable Care Act compliant employer-sponsored group medical plan (their own, mine, or my spouse's). I have already received these products and services and have not been previously reimbursed for these expenses and I will not seek reimbursement of these expenses from any other plan or party. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions on my personal tax return. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing the plan(s) for any such expense or for payment of all related income taxes on amounts paid from the plan(s) which relate to such expense. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans. If I am requesting reimbursement for work-related dependent care expenses incurred for care provided by a valid dependent care provider to an eligible dependent (for children under the age of 13 or other dependents that are physically or mentally incapable of taking care of themselves) it was while I was a participant in the plan. If I am requesting reimbursement for transit or parking benefits, these are my own personal expenses and all expenses for which reimbursement is claimed were incurred for parking at or near the business premises of my employer, or near a location from which I commute to work, and/or for regular daily direct commute from home to work and return. If no receipt is provided for commuter expenses, this service provider does not provide receipts (such as payments made by token/ticket machine, meter or cash box). If this is a Public Transportation expense, then the pass for this service in this amount is not available for purchase from my employer or plan service provider. This certification also applies to any Flex Debit Card payments where receipts are submitted for verification.

Employee's Signature

Date

HEALTH CARE ACCOUNT EXPENSE CLAIMS

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form.		**Total Health Care Expense Claim**		

*Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

Claims Administrator

Claim Form and Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies of the receipts. The receipt must show the date and type of service for the expense, the provider's name, and the amount of the expense. Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

Please be sure to number each attachment page (e.g., Page 2 of 3, Page 3 of 4, etc.). Your claim form is your cover page. After you fax or mail a claim with receipts, please do not follow up with a claim submitted via any other method.

Fax or mail this form with receipts to:

Fax: (708) 957-4662

Or mail to: My Flex
17475 Jovanna Dr., Suite 1D
Homewood, IL 60430